

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14196 CERTIFICATE OF DEATH

14188

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Valley Lee</b>		c. LENGTH OF STAY IN 1b <b>13 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Eugene</b> Last <b>Abell</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>21</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15, 1885</b>
9. AGE (In years lost birthday) yrs. <b>73</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>6</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles P. Abell</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Ellen Hammett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-09-0710</b>	
17. INFORMANT <b>Eleanor C. Abell</b>		Address <b>Valley Lee, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary accident</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary sclerosis</b> DUE TO <b>5 years</b> (c) <b>Generalized atherosclerosis</b> <b>5 yrs</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb</b> 1956, to <b>Dec 21</b> 1958, that I last saw the deceased alive on <b>Dec 10</b> 1958, and that death occurred at <b>4:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>P. J. Bear</b>		ADDRESS (Street, city or town, state) <b>Great Mills, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>P. J. Bear M.D.</b>		DATE SIGNED <b>12/22/58</b>	
22a. BURIAL, CREMATION, REBURY (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/23/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. George Episcopal</b>	22d. LOCATION (City, town, or county) (State) <b>Valley Lee, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtwn, Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 29 58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kross</b>	

CERTIFICATE OF DEATH

Form 10-1-18

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH	
5. PLACE OF DEATH		6. CAUSE OF DEATH		7. MANNER OF DEATH		8. SIGNATURE OF REGISTRAR	
9. SIGNATURE OF PHYSICIAN		10. SIGNATURE OF CORONER		11. SIGNATURE OF MINISTER		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF SURVIVORS		16. SIGNATURE OF OTHERS	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF NEXT OF KIN		19. SIGNATURE OF SURVIVORS		20. SIGNATURE OF OTHERS	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF SURVIVORS		24. SIGNATURE OF OTHERS	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF NEXT OF KIN		27. SIGNATURE OF SURVIVORS		28. SIGNATURE OF OTHERS	
29. SIGNATURE OF DECEASED		30. SIGNATURE OF NEXT OF KIN		31. SIGNATURE OF SURVIVORS		32. SIGNATURE OF OTHERS	
33. SIGNATURE OF DECEASED		34. SIGNATURE OF NEXT OF KIN		35. SIGNATURE OF SURVIVORS		36. SIGNATURE OF OTHERS	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF NEXT OF KIN		39. SIGNATURE OF SURVIVORS		40. SIGNATURE OF OTHERS	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF NEXT OF KIN		43. SIGNATURE OF SURVIVORS		44. SIGNATURE OF OTHERS	
45. SIGNATURE OF DECEASED		46. SIGNATURE OF NEXT OF KIN		47. SIGNATURE OF SURVIVORS		48. SIGNATURE OF OTHERS	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF NEXT OF KIN		51. SIGNATURE OF SURVIVORS		52. SIGNATURE OF OTHERS	
53. SIGNATURE OF DECEASED		54. SIGNATURE OF NEXT OF KIN		55. SIGNATURE OF SURVIVORS		56. SIGNATURE OF OTHERS	
57. SIGNATURE OF DECEASED		58. SIGNATURE OF NEXT OF KIN		59. SIGNATURE OF SURVIVORS		60. SIGNATURE OF OTHERS	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF NEXT OF KIN		63. SIGNATURE OF SURVIVORS		64. SIGNATURE OF OTHERS	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF NEXT OF KIN		67. SIGNATURE OF SURVIVORS		68. SIGNATURE OF OTHERS	
69. SIGNATURE OF DECEASED		70. SIGNATURE OF NEXT OF KIN		71. SIGNATURE OF SURVIVORS		72. SIGNATURE OF OTHERS	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF NEXT OF KIN		75. SIGNATURE OF SURVIVORS		76. SIGNATURE OF OTHERS	
77. SIGNATURE OF DECEASED		78. SIGNATURE OF NEXT OF KIN		79. SIGNATURE OF SURVIVORS		80. SIGNATURE OF OTHERS	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF NEXT OF KIN		83. SIGNATURE OF SURVIVORS		84. SIGNATURE OF OTHERS	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF NEXT OF KIN		87. SIGNATURE OF SURVIVORS		88. SIGNATURE OF OTHERS	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF NEXT OF KIN		91. SIGNATURE OF SURVIVORS		92. SIGNATURE OF OTHERS	
93. SIGNATURE OF DECEASED		94. SIGNATURE OF NEXT OF KIN		95. SIGNATURE OF SURVIVORS		96. SIGNATURE OF OTHERS	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF NEXT OF KIN		99. SIGNATURE OF SURVIVORS		100. SIGNATURE OF OTHERS	

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE REGISTRAR OF DEATHS, THE PHYSICIAN, THE CORONER, THE MINISTER, AND THE WITNESSES. IT IS NOT VALID IF SIGNED BY ANY OTHER PERSON.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14197

## CERTIFICATE OF DEATH

14189

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calverton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calverton Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Joseph</u> Middle <u>Beaman</u> Last				4. DATE OF DEATH <u>12-16-1958</u> Month <u>12</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 24, 1880</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Calverton County</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Francis Beaman</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Beaman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Agnes L. Beaman</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Tuberculosis</u> DUE TO (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 10, 1958</u> to <u>Dec 16, 1958</u> , that I last saw the deceased alive on <u>Dec 15, 1958</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P.J. Bean</u> M.D.				ADDRESS (Street, city or town, state) <u>Great Mills, Maryland</u> DATE SIGNED <u>12/17/58</u>			
PHYSICIAN'S NAME (Type) <u>P.J. Bean N.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Face</u>		22d. LOCATION (City, town, or county) (State) <u>Great Mills, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u> ADDRESS <u>Leonardtwn, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 19 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>	



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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14198 CERTIFICATE OF DEATH

14190

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Jenkins</u> Middle <u>Duke</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-28-1884</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware</u>	
11. BIRTHPLACE (State or foreign country) <u>St. Mary's County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Francis Duke</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ruthall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>213-03-5673</u>	
17. INFORMANT <u>Marguerite Abell Duke</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Sept -</u> , 19 <u>50</u> , to <u>Dec 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 14</u> , 19 <u>58</u> , and that death occurred at <u>8:20 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. D. Boyd</u>		DATE SIGNED <u>12/17/58</u>	
PHYSICIAN'S NAME (Type) <u>William D. Boyd M. D.</u>		<u>Leonardtown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/19/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius</u>	22d. LOCATION (City, town, or county) (State) <u>Leonardtown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>		ADDRESS <u>Leonardtown, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DEC 19 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14191

14199 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. LENGTH OF STAY IN 1b <b>13 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Maria</b> Middle <b>Louise</b> Last <b>Evans</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>11</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 2, 1910</b>
9. AGE (In years last birthday) <b>48</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Curtis</b>		14. MOTHER'S MAIDEN NAME <b>Jane Cutch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Otho Evans</b>		Address <b>Leonardtwn, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the Cervix</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-29</b> , 19 <b>58</b> , to <b>12-11</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>12-11</b> , 19 <b>58</b> , and that death occurred at <b>9 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. Samadi</b>		ADDRESS (Street, city or town, state) <b>Leonardtwn Md.</b>	
PHYSICIAN'S NAME (Type) <b>A. Samadi M.D.</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/15/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>		22d. LOCATION (City, town, or county) (State) <b>Hollywood, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtwn Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 16 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14192

## 14200 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>4 hrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Callaway</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John M. Greenwell</b>		4. DATE OF DEATH <b>Dec. 5, 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 5, 1883</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b></b> Hours <b></b> Min. <b></b>	11. IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Greenwell</b>		14. MOTHER'S MAIDEN NAME <b>Annie Lawrence</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Martha Greenwell</b>		Address <b>Baltimore, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 5, 1958</b> , to <b>Dec 5, 1958</b> , that I last saw the deceased alive on <b>Dec 5, 1958</b> , and that death occurred at <b>4:30 A.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>12/6/58</b>	
ACTUAL SIGNATURE <b>Arthur S. Kraus</b>		PHYSICIAN'S NAME (Type) <b>Arthur S. Kraus</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/8/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bethesda</b>		22d. LOCATION (City, town, or county) (State) <b>Valley Lee, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtown, Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
DEATH CERTIFICATE

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 308, LBJ Library, Washington, D.C.	
7. CAUSE OF DEATH Suicide by gunshot		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. OCCUPATION Attorney		11. EDUCATION Bachelor's Degree		12. MARITAL STATUS Single	
13. PREVIOUS ILLNESS None		14. PREVIOUS SURGERY None		15. PREVIOUS TRAUMA None	
16. PREVIOUS DRUGS None		17. PREVIOUS ALCOHOL None		18. PREVIOUS TOBACCO None	
19. PREVIOUS OTHER None		20. PREVIOUS OTHER None		21. PREVIOUS OTHER None	
22. PREVIOUS OTHER None		23. PREVIOUS OTHER None		24. PREVIOUS OTHER None	
25. PREVIOUS OTHER None		26. PREVIOUS OTHER None		27. PREVIOUS OTHER None	
28. PREVIOUS OTHER None		29. PREVIOUS OTHER None		30. PREVIOUS OTHER None	
31. PREVIOUS OTHER None		32. PREVIOUS OTHER None		33. PREVIOUS OTHER None	
34. PREVIOUS OTHER None		35. PREVIOUS OTHER None		36. PREVIOUS OTHER None	
37. PREVIOUS OTHER None		38. PREVIOUS OTHER None		39. PREVIOUS OTHER None	
40. PREVIOUS OTHER None		41. PREVIOUS OTHER None		42. PREVIOUS OTHER None	
43. PREVIOUS OTHER None		44. PREVIOUS OTHER None		45. PREVIOUS OTHER None	
46. PREVIOUS OTHER None		47. PREVIOUS OTHER None		48. PREVIOUS OTHER None	
49. PREVIOUS OTHER None		50. PREVIOUS OTHER None		51. PREVIOUS OTHER None	
52. PREVIOUS OTHER None		53. PREVIOUS OTHER None		54. PREVIOUS OTHER None	
55. PREVIOUS OTHER None		56. PREVIOUS OTHER None		57. PREVIOUS OTHER None	
58. PREVIOUS OTHER None		59. PREVIOUS OTHER None		60. PREVIOUS OTHER None	
61. PREVIOUS OTHER None		62. PREVIOUS OTHER None		63. PREVIOUS OTHER None	
64. PREVIOUS OTHER None		65. PREVIOUS OTHER None		66. PREVIOUS OTHER None	
67. PREVIOUS OTHER None		68. PREVIOUS OTHER None		69. PREVIOUS OTHER None	
70. PREVIOUS OTHER None		71. PREVIOUS OTHER None		72. PREVIOUS OTHER None	
73. PREVIOUS OTHER None		74. PREVIOUS OTHER None		75. PREVIOUS OTHER None	
76. PREVIOUS OTHER None		77. PREVIOUS OTHER None		78. PREVIOUS OTHER None	
79. PREVIOUS OTHER None		80. PREVIOUS OTHER None		81. PREVIOUS OTHER None	
82. PREVIOUS OTHER None		83. PREVIOUS OTHER None		84. PREVIOUS OTHER None	
85. PREVIOUS OTHER None		86. PREVIOUS OTHER None		87. PREVIOUS OTHER None	
88. PREVIOUS OTHER None		89. PREVIOUS OTHER None		90. PREVIOUS OTHER None	
91. PREVIOUS OTHER None		92. PREVIOUS OTHER None		93. PREVIOUS OTHER None	
94. PREVIOUS OTHER None		95. PREVIOUS OTHER None		96. PREVIOUS OTHER None	
97. PREVIOUS OTHER None		98. PREVIOUS OTHER None		99. PREVIOUS OTHER None	
100. PREVIOUS OTHER None		101. PREVIOUS OTHER None		102. PREVIOUS OTHER None	

## 14201 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Clements</b>		c. LENGTH OF STAY IN 1b <b>45 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Catherine Eleanor Harris</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>29,</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13, 1876</b>
9. AGE (In years last birthday) yrs. <b>82</b>		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>16</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Goldsboro</b>		14. MOTHER'S MAIDEN NAME <b>Harriet Farrell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>William Henry Harris Clements, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis - Cardiac failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>old age</b> DUE TO (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 6</b> , 19 <b>56</b> , to <b>Dec 29</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Dec 27</b> , 19 <b>58</b> , and that death occurred at <b>12 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Leonardtown Md.</b> DATE SIGNED <b>Charles Greenwell</b>			
ACTUAL SIGNATURE <b>Charles Greenwell</b> M.D.		DATE SIGNED <b>Leonardtown Md.</b>	
PHYSICIAN'S NAME (Type) <b>Charles Greenwell M.D.</b>		DATE SIGNED <b>Leonardtown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/31/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph</b>		22d. LOCATION (City, town, or county) (State) <b>Morganza, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		24a. REC'D BY REGISTRAR <b>Jan 2 '59</b>	
ADDRESS <b>Leonardtown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. H.</b>	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JOHN J. JOSEPH		MALE		38		JAN 15 1897		BALTIMORE, MD	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1000 N. E. ST.		LABORER		HEART DISEASE		NATURAL		HOSPITAL	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH		SECONDS OF DEATH	
JAN 20 1935		10:00 AM		10:00		00		00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. J. JOSEPH		J. J. JOSEPH		J. J. JOSEPH		J. J. JOSEPH		J. J. JOSEPH	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 20 1935		JAN 20 1935		JAN 20 1935		JAN 20 1935		JAN 20 1935	

THIS CERTIFICATE IS VALID IN ALL STATES OF THE UNION AND IN ALL COUNTRIES OF THE WORLD.

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14194

14202

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <del>Prince George's</del> <b>St. Mary's</b> <b>MARYLAND</b>				STATE <b>Maryland</b> COUNTY <b>St. Mary's</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <b>Rural Oakville</b>		<b>Life</b>		TOWN <b>Rural Oakville</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
/							
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <b>B.</b> (Middle) <b>Carroll</b> (Last) <b>Knight</b>				(Month) <b>Dec.</b> (Day) <b>28</b> (Year) <b>1958</b>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<b>Male</b>	<b>White</b>	<b>Widowed</b>	<b>Sept. 1, 1875</b>	<b>83</b> yrs.	Months <b>3</b>	Days <b>27</b>	Hours <b></b> Min. <b></b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>State Road</b>		<b>State</b>		<b>Maryland</b>		<b>U.S.A.</b>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>Benjamin Franklin Knight</b>				<b>Wilhelmina Morgan</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, No or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<b>No</b>		<b>None</b>		<b>Frank M. Knight Oakville, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>422.2 IMMEDIATE CAUSE (A)</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO</b>							
<b>(C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, lecture, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Jan 10</u>, 19<u>57</u>, to <u>Dec 28</u>, 19<u>58</u>, that I last saw the deceased alive on <u>Dec 25</u>, 19<u>58</u>, and that death occurred at <u>1:00</u> P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<i>Chad Greenwell</i>				<i>Leonardtown</i>		<i>MD</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>	
<b>Burial</b>				<b>12/31/58</b>		<b>St. John's</b>	
<b>24. REC'D BY REGISTRAR</b>				<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>	
				<i>William S. Jones</i>		<b>ADDRESS</b>	
<b>DATE</b>				<b>W. Clarke Mattingley Leonardtown, Md.</b>			
<b>JAN 2 '59</b>							





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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

14195

14203

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>St. Mary's</u>		STATE <u>Maryland</u>		COUNTY <u>St. Mary's</u>			
CITY <u>St. Mary's City</u> (If outside corporate limits, write RURAL and give nearest town)		CITY <u>Rural Lexington Pk.</u> (If rural give location)		CITY <u>St. Mary's City</u> (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS					
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Pete</u> <u>Jerome</u> <u>Knott</u>				<b>4. DATE OF DEATH</b> (Month) <u>Dec.</u> (Day) <u>26</u> , (Year) <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 1, 1906</u>	9. AGE last birthday <u>52</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>25</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roofers</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Knott</u>				14. MOTHER'S MAIDEN NAME <u>Marion A. Goddard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>220 05 1214</u>		17. INFORMANT & ADDRESS <u>Eleanor P. Knott Box 302 Lexington,</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hour.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>				<u>10 years.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1</u> , 19 <u>56</u> , to <u>Dec 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 26</u> , 19 <u>58</u> , and that death occurred at <u>3 P</u> .M. from the causes and on the date stated above.							
SIGNATURE <u>W. Clarke</u>				ADDRESS (Street, city, town, state) <u>Lexington Pk. Md.</u> DATE SIGNED <u>12-27-58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/29/58</u>		NAME OF CEMETERY OR CREMATORY <u>St. James</u>		LOCATION (City, town, or county) (State) <u>St. Mary's City, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley Leonardtown, Md.</u>			
DATE <u>JAN 2 '59</u>							



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
14204 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 FilmG257 12-23-58 et

Reg. Dist. No.

14198

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Piney Point</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St Mary's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Lockwood</u> Last <u>Lockwood</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Approx. 65</u> yrs.
9. AGE (In years last birthday) <u>65</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Baxens</u>	
14. MOTHER'S MAIDEN NAME <u>Rosanna Watson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>	
16. SOCIAL SECURITY NO. <u>578 16 3257</u>		17. INFORMANT Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhagic Pancreatitis</u> <u>58%</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c), stating the underlying cause last. (c) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> b. <u>  </u> c. <u>  </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>  </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Russell S. Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12/11/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-13-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Luke M.E</u>		22d. LOCATION (City, town, or county) (State) <u>Piney Point, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>		ADDRESS <u>Leonardtown, Md</u>	
24a. REC'D BY REGISTRAR <u>DEC 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Faint text, possibly "JOHN DOE"]

2. SEX: [ ] MALE [ ] FEMALE

3. AGE: [ ] YEARS

4. DATE OF DEATH: [ ] / [ ] / [ ]

5. PLACE OF DEATH: [ ] HOME [ ] HOSPITAL [ ] OTHER [ ]

6. CAUSE OF DEATH: [ ] HEART DISEASE [ ] CANCER [ ] INFECTION [ ] TRAUMA [ ] OTHER [ ]

7. MANNER OF DEATH: [ ] NATURAL [ ] ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ] UNDETERMINED [ ]

8. SIGNATURE OF MEDICAL EXAMINER: [ ]

9. SIGNATURE OF WITNESS: [ ]

10. SIGNATURE OF CORONER: [ ]

ALL INFORMATION ON THIS CERTIFICATE IS TO BE FURNISHED TO THE STATE DEPARTMENT OF HEALTH, DIVISION OF VITAL RECORDS, 1001 CALIFORNIA STREET, SACRAMENTO, CALIFORNIA 95833.

NO FEE IS CHARGED FOR THIS CERTIFICATE.

THIS CERTIFICATE IS VALID FOR THE STATE OF CALIFORNIA ONLY.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**14205 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14197

Reg. Dist. No.

**FOR STATE HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Ohio</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington Court House</b> <i>72 x 3</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>616 East Temple Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Henry</b> Last <b>Melvin</b>				4. DATE OF DEATH Month <b>December</b> Day <b>14</b> Year <b>19 58</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/25/1912</b>		9. AGE (In years last birthday) <b>46</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Air craft</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>O.L. Melvin</b>				14. MOTHER'S MAIDEN NAME <b>Kathryn Albert</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>288-01-0627</b>		17. INFORMANT <b>L.C. Martin, Box 128 Lexington Park, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>1 hour.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>W.H. Patrick</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12-15-58</b>	
EXAMINER'S NAME (Type) <b>W.H. PATRICK MD</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>12/15/58</b>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Washington Court House, Ohio.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>				24a. REC'D BY REGISTRAR <b>DEC 17 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
1920 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HYGIENIST

NAME OF DECEASED  
DATE OF DEATH

AGE  
SEX

PLACE OF BIRTH  
CITY

DATE OF BIRTH  
PLACE OF DEATH

CAUSE OF DEATH  
MANNER OF DEATH

EDUCATION  
OCCUPATION

RELIGION  
MARRIAGE

PREVIOUS ILLNESS  
PREVIOUS SURGERY

PREVIOUS TRAUMA  
PREVIOUS ACCIDENT

PREVIOUS DRUGS  
PREVIOUS TOBACCO

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINER

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF SIGNER

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

DATE OF DEATH



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 237 12-31-58 <sup>ams</sup>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14198

14206 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. LENGTH OF STAY IN 1b <b>3hrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>Milburn</b> Last <b>Milburn</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>12,</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1920 38</b>
9. AGE (In years last birthday) yrs. <b>38</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day labor</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Compton, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wilson Milburn</b>		14. MOTHER'S MAIDEN NAME <b>Jannie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>May Agnes Milburn Leonardtown, Maryland</b>	
17. INFORMANT <b>May Agnes Milburn Leonardtown, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Exposure</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>8:35 A.M.</b> <b>10:40 A.M.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12</b> , 19 <b>58</b> , to <b>12</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>did not see him</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Charles Greenwell</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. Charles Greenwell M.D.</b>		<b>Leonardtwn, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/15/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Aloysius</b>	22d. LOCATION (City, town, or county) (State) <b>Leonardtwn, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 16 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

# STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS OFFICE OF THE REGISTRAR

STATE OF NEW YORK  
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
OFFICE OF THE REGISTRAR

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14199

14207

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>Rural</b>			
3. NAME OF DECEASED (Type or print) First <b>Ernest</b> Middle <b>-</b> Last <b>Moore</b>				4. DATE OF DEATH Month <b>12/</b> Day <b>4/</b> Year <b>19 58</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/17/1886</b>		9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph P. Moore</b>				14. MOTHER'S MAIDEN NAME <b>L. Jane Townsend</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WW 1 218-12-2155</b>		17. INFORMANT <b>Samuel Moore- 414 Bryant Nursery Rd . Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Wm. D. Boyd, MD</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Wm. D. Boyd, MD</b>				DATE SIGNED <b>12/4/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/9/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 9 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. H... ..</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 14208 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>				c. LENGTH OF STAY IN 1b <b>14 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Albert</b> Last <b>Murray</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>12,</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 18, 1906</b>		9. AGE (In years last birthday) yrs. <b>51</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Naval Air Station</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Vance Murray</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Dorothy Murray</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 21c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 21f. (City or town) (County) (State)							INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
21. I certify that I attended the deceased from _____, 19____, to <b>11 Dec</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>14 Dec</b> , 19 <b>58</b> , and that death occurred at <b>6:49</b> M, from the causes and on the date stated above.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
ACTUAL SIGNATURE <b>Ernest D. Rehm</b>				ADDRESS (Street, city or town, state) <b>Lexington Park, Md</b>		DATE SIGNED <b>14 Dec 58</b>	
PHYSICIAN'S NAME (Type) <b>Ernest Rehm M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/16/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rock Fish A.M.E.</b>		22d. LOCATION (City, town, or county) (State) <b>Wallace, North Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Shaw &amp; Son Wallace, North Carolina</b>				24a. REC'D BY REGISTRAR <b>DEC 16 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

<p>1. Name of deceased: <u>JOHN W. SMITH</u></p>		<p>2. Date of death: <u>1945</u></p>	
<p>3. Place of death: <u>Home</u></p>		<p>4. Age: <u>65</u></p>	
<p>5. Sex: <u>Male</u></p>		<p>6. Race: <u>White</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1945</u></p>		<p>12. Place of registration: <u>Baltimore</u></p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS AND STATISTICS ACT OF 1938, AS AMENDED.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14201

## 14209 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. LENGTH OF STAY IN 1b <b>8hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Chaptico</b>	
		d. STREET ADDRESS <b>1</b>	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Essie</b> Middle <b>Belle</b> Last <b>Penn</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>7,</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 1, 1884</b>
9. AGE (In years lost birthday) yrs. <b>74</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>8</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Noble L. Penn</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Barber</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs Sadie Penn Chaptico, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malnutrition</b> DUE TO <b>334X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerosis Cerebral</b> DUE TO <b>4 mental deficiency</b> (c) <b>ankeloma of almost all joints</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>5 years</b> <b>since Birth</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>52</b> to <b>Dec 7</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Dec 7</b> , 19 <b>58</b> , and that death occurred at <b>5:30 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b></b> DATE SIGNED <b>12/10/58</b>			
ACTUAL SIGNATURE <b>William D. Boyd</b> M.D.			
PHYSICIAN'S NAME (Type) <b>William D. Boyd M.D.</b>		<b>Leonardtwn, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/10/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bethel M.E.</b>	22d. LOCATION (City, town, or county) (State) <b>Budds Creek, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtwn, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 12 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14202

Items 9 & 18 Film 257 1-9-59 ams

14210

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Marys City</b>			c. LENGTH OF STAY IN 1b <b>3 1/2 mo.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <b>Rural</b>		
3. NAME OF DECEASED (Type or print) <b>Jace Thomas Pierce</b>			4. DATE OF DEATH Month <b>12</b> / Day <b>8</b> / Year <b>19 58</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>15 August 1958</b>		9. AGE (In years last birthday) yrs. <b>3</b> Months <b>23</b> Days <b>26</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Jerry Thomas Pierce</b>		
14. MOTHER'S MAIDEN NAME <b>Patricia Ann Moore</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		
16. SOCIAL SECURITY NO. <b>----</b>			17. INFORMANT <b>J.T. Pierce - St. Marys City, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchitis pneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>(all other diseases)</b> (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(1) Cardiomegaly (52.5 gm. vs 23 gm. normal), (2) Pulmonary edema, (3) Microgyria.</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Bethesda Naval Hosp.</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Wm. D. Boyd MD</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12/10/58</b>	
EXAMINER'S NAME (Type) <b>Wm. D. Boyd, MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/11/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>			24a. REC'D BY REGISTRAR <b>DEC 15 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

2051 254XV5



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14203

## 14211 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>St Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>St Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>#2 Van Buren St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St Mary's</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Sommerville</u> Last <u>Sommerville</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Color</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-10-58</u>
9. AGE (In years last birthday) yrs. <u>7 days</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas Daniel Sommerville</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Delores Spears</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>773.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cause undetermined</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12 Dec</u> , 19 <u>58</u> , to <u>11 Dec</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11 Dec</u> , 19 <u>58</u> , and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Gill</u> M.D.		ADDRESS (Street, city or town, state) <u>Leonardtown, Md</u>	
DATE SIGNED <u>12/14/58</u>			
PHYSICIAN'S NAME (Type) <u>Joseph E. Gill M.D.</u>		<u>Leonardtown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-12-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St John's</u>		22d. LOCATION (City, town, or county) (State) <u>Hollywood Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McClark Mattingly</u> ADDRESS <u>Leonardtown, Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 16 58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**14212 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**14204**

Reg. Dist. No.

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form-PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel Grove</b>		c. LENGTH OF STAY IN lb <b>58 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel Grove</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>Charlotte Ledley Wallace</b>			4. DATE OF DEATH <b>Dec. 27, 19 58</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 6, 1876</b>	9. AGE (in years last birthday) <b>82 yrs.</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>21</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>County</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Benjamin Ledley</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Wilson</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>213 40 8366</b>			17. INFORMANT <b>Mrs J. Harold Burroughs</b> Address <b>Mechanicsville, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Severe Crushing Injuries of Entire Body</b> DUE TO (b) <b>30 sec.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Run over by <del>car</del> automobile</b>			
20c. TIME OF INJURY Month, Day, Year <b>6.15 p.m. 12/27/ 58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway 235</b>	
20f. (City or town) (County) (State) <b>Laurel Grove, St. Mary's Md.</b>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>W.H. Patrick</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>William H. Patrick M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>12/30/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>
22d. LOCATION (City, town, or county) (State) <b>Laurel Grove, Md.</b>			22e. REC'D BY REGISTRAR		
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur J. Kraus</b>		
ADDRESS <b>Leonardtwn, Md.</b>			DATE <b>JAN 2 '59</b>		

THE UNIVERSITY OF CHICAGO

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

14205

## CERTIFICATE OF DEATH

14213

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>St. Mary's</u>		STATE <u>Maryland</u> COUNTY <u>St. Mary's</u>		CITY <u>Charlotte Hall</u>		CITY <u>Charlotte Hall</u>	
(If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		(If outside corporate limits, write RURAL and give nearest town)		(If rural give location)	
TOWN <u>Charlotte Hall</u>		<u>Life</u>		TOWN <u>Charlotte Hall</u>		STREET ADDRESS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				/			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>Sidney</u> (Middle) <u>Woodland</u> (Last)				Dec. <u>10</u> , 19 <u>58</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>Jan. 29, 1897</u>	<u>61</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Day labor</u>		<u>farm</u>		<u>Charlotte Hall, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Joseph Woodland</u>				<u>Anna Curtis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u>		<u>WW 1</u>		<u>Agnes Curtis Charlotte Hall, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
443X IMMEDIATE CAUSE (A) <u>ACUTE CARDIAC FAILURE (HYPERTENSIVE)</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>CARDIO VASCULAR DISEASE</u>						<u>2 HOURS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>ESSENTIAL HYPERTENSION</u>						<u>15 YEARS</u>	
C) _____							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>November 19, 48</u> , to <u>December 10, 58</u> , that I last saw the deceased alive on <u>December 3, 1958</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>John H. Guilford</u>				<u>Hughesville, Md.</u>		<u>12/12/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/13/58</u>		<u>St. Joseph's</u>		<u>Morganza, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DEC 16 '58</u>		<u>Arthur S. Kraw</u>		<u>W. Clarke Mattingley</u>		<u>Leonardtwn, Md.</u>	



14214

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>St. Marys</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mechanicsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mechanicsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rural</b>		d. STREET ADDRESS <b>Rural</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>David M. Zimmerman</b>		4. DATE OF DEATH Month Day Year <b>12/1 1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/3/1875</b>
9. AGE (In years lost birthday) <b>83</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farming</b>	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>David Zimmerman</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Mink</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>----</b>	
17. INFORMANT <b>John S. Zimmerman - Mechanicsville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anteroseptal Cardiovascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10-1</b> , 19 <b>58</b> , to <b>12-1</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>12-1</b> , 19 <b>58</b> , and that death occurred at <b>8:00 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>David L. Morseman</b> M.D.		ADDRESS (Street, city or town, state) <b>Mechanicsville, Md.</b>	
DATE SIGNED <b>12/2/58</b>			
PHYSICIAN'S NAME (Type) <b>David L. Morseman, MD</b>		<b>Mechanicsville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/5/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Menonite</b>	22d. LOCATION (City, town, or county) (State) <b>Loveville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 9 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Robert A. P. [Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



